Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOWARD B COTLER MD
GULF COAST SPINE CARE LTD PA
1200 BINZ #670
HOUSTON TX 77004

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative Box

Box Number 44

MFDR Tracking Number

M4-05-9056-01

MFDR Date Received

MAY 26, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "1. There is no code for Anterior Lumbar Diskectomy – we have always used 22899 (63077 is the closest) and we are reimbursed. 2. Bone Morphogenic Protein has not been assigned a CPT code, but is indeed a very isolated procedure, see letter & operative report. 3. Insert Spine Device. * All denied with no reasonable explanation – no denial codes given."

Amount in Dispute: $6,750.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary as stated on the Table of Disputed Services: Paid in accordance with Fee Schedule fair & reasonable."

Response Submitted by: Gallagher Bassett Services, 6404 International Pkwy Ste. 2100, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 11, 2004	CPT Code 22899 CPT Code 22899 CPT Code 22842	$6,750.91	$1,055.91

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. 28 Texas Administrative Code §134.202 sets out the guidelines for reimbursement of health care.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 1, 2004 and April 22, 2005
   - * - No MAR
   - *04663 PEC code not defined
   - *01956 PEC code not defined
   - * - Denial after reconsideration.
   - *04835 PEC code not defined

Findings

1. According to the bill, the requestor billed CPT Code 22899 – Unlisted Procedure Spine was used for Anterior Lumbar Diskectomy. According to Dr. Howard B. Cotler, MD, Orthopaedic Surgeon, "I have coded an anterior lumbar discectomy as an unlisted code because there is not specific code available for the surgical procedure performed." CPT Code 22899 – Unlisted Procedure Spine was also billed for Bone Morphogenic Protein as this procedure has not been assigned a CPT Code. In accordance with 28 Texas Administrative Code §134.202(b) and (c)(1) and (6) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section. (c)To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1)for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (6)for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments.

   The insurance carrier, or it's auditing company did not assign a relative value for this code; therefore, these two procedures will be reviewed 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   28 Texas Administrative Code §133.307(g)(3)(D), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated. As a result, the amount ordered is $0.00
2. The requestor billed CPT Code 22842 - Posterior segmental instrumentation. In accordance with §134.202(c)(1) the maximum allowable reimbursement for this procedure is $1,055.91 the insurance carrier paid $0.00. Review of the operative report supports the services were rendered as billed. As a result, the amount ordered is $1,055.91.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,055.91.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,055.91 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 14, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.